



## **MyIdahoCNP User Authorization Request**

Instructions: Complete and return to SDE-Child Nutrition Programs for access to MyIdahoCNP. Please write legibly; how we interpret what you write is how we will set your user name and password up in the system.

Representing: \_\_\_\_\_

☐ I am an employee of a Food Service Management Company (not on the payroll of the sponsor I am representing).  
Sponsor Name(s) \_\_\_\_\_

User Name: \_\_\_\_\_ Title: \_\_\_\_\_

First, M.I. Last

User ID: \_\_\_\_\_

Up to twelve characters long. WRITE LEGIBLY!

Password: \_\_\_\_\_

Up to twelve characters long. Passwords ARE case sensitive in MyIdahoCNP. WRITE LEGIBLY!

Email Address: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

Reminder Question (select one): ☐ Birth Year ☐ Mother's maiden name  
☐ Name of your first pet ☐ Year you graduated from high school

Answer: \_\_\_\_\_

Component(s) to be used: ☐ National School Lunch Program (NSLP) ☐ Child and Adult Care Food Program (CACFP)  
☐ Summer Food Service Program (SFSP) ☐ USDA Foods

I understand that the use of the user name and password to access the Idaho State Department of Education (SDE) – Child Nutrition Programs (CNP) MyIdahoCNP web site is equivalent to an original signature for purposes of official documentation. By using the user name and password, I certify that the information transmitted is complete and accurate.

User names and passwords are individually assigned to maintain integrity and **may not be shared**. If another user accesses the system under my user name and password and provides false information, I understand that I will be responsible for the content of the information transmitted to the Idaho SDE.

If I believe that my user name and password have been compromised, I will notify the Idaho SDE – CNP immediately and be assigned a new user name and password.

If access to the MyIdahoCNP system is no longer needed, I understand that it is my responsibility to terminate access.

\_\_\_\_\_  
Signature Authorized User Name (Please Print) Date

Superintendent/Director Signature: \_\_\_\_\_  
(Superintendent or director must sign in order for this employee to gain access to MyIdahoCNP)

Termination of access: \_\_\_\_\_  
Employee Name to be terminated

Reason: ☐ No longer an employee ☐ Change in job task ☐ Security compromised

Requested by: \_\_\_\_\_ Date: \_\_\_\_\_